

BR

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF
ILLINOIS

FILED

EASTERN DIVISION

JUN - 5 2008

JUN 5, 2008

MICHAEL W. BOBBINS

CLERK, U.S. DISTRICT COURT

IN RE LOUIS C. SHEPTIN, 1
MOVANT

82-CR-555

07-CR-197

08-CV-1944

08-CV-116

DIRECTED TO THE HONORABLE JUDGES KENNEDY, KOCORAS AND
THE MOST HONORABLE GEORGE LINDBERG

MAY IT PLEASE THE HONORABLE COURT:

EMERGENCY NOTICE

COMES NOW your MOVANT, LOUIS C.

SHEPTIN AND RESPECTFULLY SHOWS THAT

HONORABLE COURT THE ATTACHED MEDICAL TREATMENT

REFUSAL. YOUR MOVANT HAS CONTINUALLY NOTIFIED

MEDICAL STAFF OF ALLERGIC REACTIONS TO MEDICATION

"LISINAPRIL", INCLUSIVE OF SEVERE PAIN IN LIMBS,

DIZZINESS, RETENTION OF URIN, SHORTNESS OF

BREATH, KIDNEY PAIN. EXHIBITS A AND E

UNFORTUNATELY MEDICAL STAFF (DR. HERNANDEZ)

IGNORE THESE SYMPTOMS, AND CONTINUE TO
PERSCRIBE THIS MEDICATION! WITHOUT EXAM.

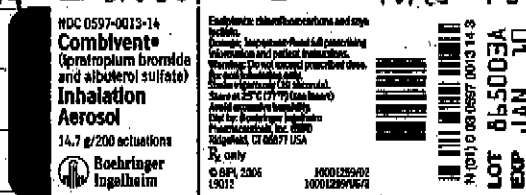
AS SHOWN ATTACHED MOVANT'S MEDICAL/
CARDIAC CONDITION IS WORSENING. MOVANT'S
LEGS ARE SWELLING AND MOVANT DOES NOW
HAVE CONGESTIVE HEART FAILURE, (SEE
ATTACHED). MOVANT STARTED SHOWING SYMPTOMS
OF CHF SHORTLY AFTER ARRIVING AT MEDICAL
CENTER IN SPRINGFIELD, MOVANT'S WEIGHT HAD
RISEN (APPARENTLY DUE TO WATER RETENTION).
SPRINGFIELD GAVE MOVANT BREATHING TREATMENTS,
AND UNFORTUNATELY STARTED MOVANT ON LISINPRIL
WHICH IS A TREATMENT FOR CHF, HOWEVER THE
SIDE EFFECTS WERE SO BAD, MOVANT WAS

HOSPITALIZED. NEVERTHELESS, THE MEDICATION WAS NOT CHANGED. MOVANT RETURNED TO MCC ON MONDAY, MAY 19, 2008, AND SINCE THEN HAS NOT BEEN EXAMINED, NOR CALLED TO THE MEDICAL DEPARTMENT, HOWEVER MOVANT VIA INSTITUTIONAL MAIL WAS CONTACTED DR. HARVEY WITHOUT RESPONSE (SEE ATTACHED), TWICE.

BECAUSE CONGESTIVE HEART FAILURE IS A FATAL CONDITION, IF NOT TREATED CORRECTLY AND PROMPTLY, AND BECAUSE LISINAPRIL CAUSES ME TO RETAIN MORE FLUIDS, I BELIEVE THE MEDICAL DEPARTMENT IS FLERTING WITH ^{MY} DEATH.

I REQUEST THE HONORABLE COURT TO INTERVENE ON MY BEHALF, OR ALLOW ME TO GO TO UIC OR NORTHWESTERN, IMMEDIATELY

I WAS TOLD BY DR. MOHAMMED ELADREBY
 THAT "SOME PEOPLE CANNOT TOLERATE LISINPAPIL,"
 AND "IF YOU HAVE ANY SIDE EFFECTS, LET ME
 KNOW IMMEDIATELY." I DID NOT HAVE THE
 OPPORTUNITY TO TELL HIM, HOWEVER MY
 CARDIAC CONDITION IS WORSENING, AND AS
 EVIDENCED BY THE ATTACHED EXHIBIT
 MARKED "A", I HAVE CHF, AND AS EVIDENCED
 BY "B", "C" AND "D", I'VE ATTEMPTED RESOLUTION,
 AND AS SHOWN BY EXHIBIT "E" - THIS IS PROTRACTED.



THIS MEDICATION WAS GIVEN IN SPRINGFIELD

- 4 -

U I STATED THIS MEDICATION SHORTLY BEFORE
 LEAVING SPRINGFIELD, BECAUSE MY CHF STARTED
 GETTING WORSE AND MY LUNGS STARTED RETAINING
 FLUID IN THEM.

TO HELP COMBAT MY CHF AND HELP ME
 COUGH UP FLUID(S), HOWEVER I'M NOT SO
 SURE THIS IS STANDARD OF CARE FOR
 CONGESTIVE HEART FAILURE^{II}, AND I'M
 NOT SO SURE DR. HARVEY HAS THE COM-
 PETENCE TO TREAT MY CARDIAC CONDITION.
 NOT ONCE HAS HE CONSULTED WITH A
 CARDIOLOGIST, NOR HAVE I SEEN ONE HERE.

I BEG THE COURT'S INDULGENCE IN THIS
 CASE AND I HUMBLY APOLOGIZE, SINCERELY
 APOLOGIZE, AND RESPECTFULLY REQUEST THAT
 THE HONORABLE COURT TAKE JUDICIAL NOTICE OF
 THE ATTACHED DOCUMENTATION. PLEASE HELP ME.

ATTACHMENTS EXHIBITS A-E
 May 31, 2008

Respectfully yours,
 [Signature]

HOWIE C. SHERMAN
 71 W. VAN BUREN ST
 CHICAGO, IL 60661

U.S. Department of Justice
Federal Bureau of Prisons

Medical Treatment Refusal
(Rechazo de Tratamiento Médico)

May 31, 2008
Date (Fecha)

1. Shaydn, Louis 90355-024
(Name and Registration Number) (Nombre y Número de Registro)

refuse treatment recommended by the Federal
(rechaza el tratamiento recomendado por el Personal)

Bureau of Prisons Medical staff for the following condition(s):
Médico del Bureau Federal de Prisiones, por las siguientes razones:

DESCRIBE IN LAYMAN'S TERMINOLOGY

(DESCRIBA EN TERMINOLOGIA COMUN Y CORRIENTE)

Urgentive Heart Failure

The following treatment(s) was/were recommended:

(El siguiente tratamiento(s) fue/fueron recomendado(s)):

Lisopril 20 mg i bid

"I think I'm allergic to Lisopril"

Federal Bureau of Prisons Medical staff members have carefully explained to me that the following possible consequences and/or complications may result because of my refusal to accept treatment:

(Los miembros del personal Médico del Bureau Federal de Prisiones me ha explicado cuidadosamente las posibles consecuencias o complicaciones siguientes que pueden resultar por causa de mi rechazo a aceptar tratamiento):

Worsening of condition

I understand the possible consequences and/or complications, listed above, and still refuse recommended treatment. I hereby assume all responsibility for my physical and/or mental condition, and release the Bureau of Prisons and its employees from any and all liability for respecting and following my expressed wishes and directions:

(Me doy por enterado de las posibles consecuencias o complicaciones enlistadas arriba, y aun así me rehúso al tratamiento recomendado. Por medio de la presente, asumo toda responsabilidad por mi condición física o mental, y relevo al Bureau de Prisiones y a sus empleados de cualquiera y toda responsabilidad por causa de respetar y seguir mis expresos deseos y direcciones.)

Joe Nyles
Patient's Signature and Date

5/31/08
(Firma del Paciente y Fecha)

W. [Signature]
Signature of Witness and Date

5-31-08
(Firma del Testigo y Fecha)

E. [Signature]
Signature of Witness and Date

5-31-08
(Firma del Testigo y Fecha)

Original - Inmate's Medical Record
Canary - Hospital File
Pink - To Inmate



"A"

BP-S148.055 INMATE REQUEST TO STAFF CDFRM

SEP 98

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) <i>DR HANLEY, CD</i>	DATE: <i>5/26/08</i>
FROM: <i>SHEPHERD, LOUIS</i>	REGISTER NO.: <i>90355024</i>
WORK ASSIGNMENT: <i>O/A</i>	UNIT: <i>13</i>

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

DEAR SIR: NEED TO CHANGE MY RX FOR CISOVAPRI

LETS SWEETEN REAL BAD - RETAINING FLUN.

I HAVE IN THE PAST TAKEN LASIX AND ROMASSIN

WITHOUT PROBLEMS, WILL YOU CHANGE THE SCRIPT?

SENT YOU A REQUEST LAST WEEK

(Do not write below this line)

DISPOSITION:

NO ANSWER

Signature Staff Member

Date

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86
and BP-S148.070 APR 94



copy
13

BP-S148.055 INMATE REQUEST TO STAFF CDFRM

SEP 98

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) <i>DR. NARVEY CLINICAL DIRECTOR</i>	DATE: <i>5-19-07</i>
FROM: <i>SHEPSON, LOUIS</i>	REGISTER NO.: <i>90355-ULV</i>
WORK ASSIGNMENT: <i>U/A</i>	UNIT: <i>13</i>

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

SIR. LEGS ARE SWELLING. NEED LASIK.

LISONIDAZOL COMEG HAVING AWFUL REACTION -

DOESN'T WORK, CAUSING ME BIG PAIN IN

KIDNEYS, LESS, AND DOESN'T HELP. PLEASE

SEE ME.

(Do not write below this line)

DISPOSITION:

NO ANSWER

Signature Staff Member

Date

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86
and BP-S148.070 APR 94



*copy
KDK*

COPY

MCC-CHICAGO
INMATE SICK CALL SIGN-UP FORM (Solicitud para Servicios Médicos o Dentales)

INSTRUCTIONS (Check one) Instrucciones (Indique uno) MEDICAL ☒ DENTAL ☐

1. Name (Nombre): SHEPHERD, LOUIS Date (Fecha): 5/18/08
2. Reg Number (Número de Registro): 90355-014 Age (Edad): 50
3. Housing Unit (Unidad de vivienda): 13 Work Place (Lugar de Trabajo): N/A
4. Complaint/Problem: Be very specific (Queja/Problema - Sea bien específico)
LISTINOPIRIL MEDS WHICH WERE REC'D IN SPS ARE CAUSING ME
BAD SIDE EFFECTS. THIS WAS SUPPOSED TO BE A WATER PILL &
HAVE A SMOOTH TASTE. MYSTERY MEDICATIONS CAN NOT BE TAKEN WITH MY PRESENT
MEDS - BAD INTERACTIONS ARE OCCURRING - DIZZY - DROWSY (EXPLAINING)
DOESN'T HELP ME GET RID OF WATER
5. How long have you had this problem? (¿Cuánto tiempo ha tenido este problema?) SINCE 5/11/08
6. Are you taking any prescription or over the counter medications at this time? Which ones? (¿Está tomando medicinas actualmente, con o sin receta? ¿Cuáles?) YES (NAME
YASAD, TETRACYCLINE (NAME
7. Are you allergic to any medications? (¿Es alérgico a algún medicamento?) YES LISTINOPIRIL
YASAD, TETRACYCLINE (NAME
8. Are you having any pain? (¿Está sintiendo dolor?) YES If yes, rate the pain from 0-10 8
(0= no pain, 10+ worst pain ever)
(Si es sí, califíquelo de 0 (no duele) a 10 (el peor dolor que ha sentido))
9. Signature (Firma): [Signature]

BRING ALL YOUR PRESCRIBED & COMMISSARY MEDICATIONS TO YOUR APPOINTMENTS WITH YOUR PROVIDER.

POR FAVOR TRAIGA TODAS LAS MEDICINAS RECETADAS Y DE LA COMISARIA A SUS CITAS CON SU PROVEEDOR DE SERVICIOS DE SALUD.

TO BE COMPLETED BY MEDICAL PERSONNEL

1. Date triaged: _____ Vital Signs: _____
2. Subjective Information: _____
3. Objective Information: _____
5. Medical Staff Signature and Date: _____

NO ANSWER
AS of 6/2

e7r

DR. DAVID HARVEY EVEN HAD NOTICE OF
REACTION ON 5/27/08, DISPUTE HIS
FAILURE TO ANSWER B, C, D, AND E
THIS MATTER SURPASSES THE EXHAUSTION
REQUIREMENT - CONGESTIVE HEART FAILURE IS
TIMELY, PROGRESSIVE AND FATAL.

ving treatment(s) was/were recommende

siguiente tratamiento(s) fue/fueron recomen

Lisingspil 20mg

Federal Bureau of Prisons Medical staff members have carefully explained to me that the following possible consequences and/or complications may result because of my refusal to accept treatment:

(Los miembros del personal Médico del Bureau Federal de Prisiones me ha explicado cuidadosamente las posibles consecuencias o complicaciones siguientes que pueden resultar por causa de mi rechazo a aceptar tratamiento).

Death

I understand the possible consequences and/or complications, listed above, and still refuse recommended treatment. I hereby assume all responsibility for my physical and/or mental condition, and release the Bureau of Prisons and its employees from any and all liability for respecting and following my expressed wishes and directions.

(Me doy por enterado de las posibles consecuencias o complicaciones enlistadas arriba, y aun así me rehúso al tratamiento recomendado. Por medio de la presente, asumo toda responsabilidad por mi condición física o mental, y relevo al Bureau de Prisiones y a sus empleados de cualquiera y toda responsabilidad por cause de respetar y seguir mis expresos deseos y direcciones.)

Signature of Witness and Date

(Firma del Testigo y Fecha)

Signature of Witness and Date

(Firma del Testigo y Fecha)

Original - Inmate's Medical Record

Canary - Hospital File

Pink - To Irrigate

Patient's Signature and Date: _____

(Firma del Paciente y Fecha)

Dr. Henry
I HAVE CONTINUOUS
COMPLAINING THIS HEADACHE
CAUSES ME TO GET
DIZZY - PAIN IN LETS
AND DOES NOT
WORK E